Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
1	**DSHS rates and billing guidelines**	05/01/03	**Q.** Are the contracted managed care health plans required to establish payment policy based on **DSHS rates and billing guidelines**? **A.** DSHS billing guidelines are established for DSHS use. Contracted managed care health plans can pay DSHS rates or they can pay more or less than DSHS rates, any negotiation of payment must take place between the health plan and the provider and the state/DSHS cannot be involved in those discussions.
2	**Cord blood transplant**	05/05/03	**Q.** Does DSHS cover **cord blood transplant** as a subset of stem cell transplant? **A.** Yes, a Cord blood transplant is covered as a subset of a stem cell transplant. Although, under Healthy Options, the health plan determines the medical necessity of this benefit.
3	**Surgery paid by DSHS fee-for-service** **UPDATED: 01/01/06**	05/05/03	**Q.** If a Healthy Options client receives a **surgery paid by DSHS fee-for-service** (for example Gastric Bypass surgery) and experiences complications, who is responsible for the cost related to the complications? **A.** ~~When a surgery is provided under fee-for-service, any complications and/or medications that are directly related to the surgery are covered by DSHS fee-for-service.~~ **UPDATED: 07/01/04 –** Prior to 2006 there is no reference to "complications" in the Healthy Options contract. The **surgery paid by DSHS fee-for-service** (for example Gastric Bypass surgery) is covered under a special authorization by DSHS. Any payment issues related to services provided related to the surgery should be reviewed by the DSHS/HRSA authorization section. Medically necessary services (as determined by the plan) not covered by DSHS are the responsibility of the managed care plan. **UPDATED: 01/01/06 –** In 2006, language addressing "complications" was added into the Healthy Options contract. *"Complications resulting from an excluded service are also excluded for a period of one hundred and eighty (180) calendar days following the occurrence of the excluded service not counting the date of service, except for complication resulting from surgery for weight loss or reduction, which are excluded for a period of three hundred and sixty-five (365) calendar days following the occurrence of the excluded service not counting the date of service. Thereafter, complications resulting from an excluded service are a covered service when they would otherwise be a covered service under the provisions of this Contract."*
4	**Maximum number of patients per PCP**	05/05/03	**Q.** Can the state's **maximum number of patients per Primary Care Provider (PCP)** be raised to 2000 clients per PCP? **A.** There is currently no maximum number of clients per PCP identified according to the Healthy Options contract.

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
5	**Medical necessity**	05/05/03	**Q.** Can managed care organizations (Healthy Options health plan) determine **medical necessity** regarding incontinence products? **A.** Yes, but all medical necessity decisions must be done on a case-by-case basis. There can be no global medical necessity decision regarding a particular service.
6	**Incarcerated clients**	05/05/03	**Q.** If a Healthy Options client is **incarcerated** and put in the hospital, then is un arrested during the hospital stay, who (DSHS or the health plan) is the responsible for the services? **A.** Payment for hospital charges are based on the status of the client at the time of admission.
7	**Contact the pre assigned client**	05/12/03	**Q.** The Healthy Options plans receive enrollment information from MAA on a weekly basis informing them in advance of a client's request to enroll with the health plan for the following month. Is it permissible for the health plan to **contact the pre assigned client** by phone or mail and verify their Primary Care Provider (PCP) choice so they can be sure to get the correct PCP on their plan ID cards? **A.** Yes, it is permissible for the health plan to contact the pre assigned clients by phone or mail and verify their Primary Care Provider (PCP) choice so they can be sure their plan ID cards correctly display their enrollment information. The information shared by MAA with the health plan falls under the Health Insurance Portability and Accountability Act (HIPAA) description of using and disclosing Personal Health Information (PHI) when performing Treatment, Payment or Healthcare Operations (TPO) activities. Additionally, health plans are covered entities under HIPAA and are obligated to follow the same rules and regulations when handling protected health information.
8	**Certified nurse midwives (CNM) and licensed midwives (LM)**	05/12/03	**Q.** Are Healthy Options plans required to contract with **certified nurse midwives (CNM) and licensed midwives (LM)**? **A.** Yes, according to the Office of Insurance Commissioner under RCW 48.42.100 and WAC 284-43-250, health carriers must contract with all types of women's health care providers including licensed midwives (LM) [RCW 18.50] certified nurse midwives (CNM) [RCW 18.79], and obstetricians.

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
9	**Billing the Client**	05/12/03	**Q.** When a client is seen at a providers office, and they pay $20 for a deposit and then 1-2 months later the client presents a coupon is the providers office required to refund the money right away or can it be billed to DSHS and then send the patient the money? **A.** A client cannot be billed or made to pay "$20 as a deposit" if they are eligible for Medical Assistance and just neglected to bring their identification card at the time of service. The provider is responsible for verifying eligibility prior to rendering a service. The provider may require the client to go get their ID card or call MAA and verify eligibility. According to the WAC 388-502-0160 (4) "If a client becomes eligible for a covered that has already been provided because: (a) applied to the department for medical services later in the same month..... or (b) receives a delayed certification.....The provider must promptly refund any payment received and then bill DSHS.... or (c) receives a retroactive certification..... The provider may refund any payment received and after refunding may bill DSHS for the service." In all three cases cited in the WAC, the provider must refund the money collected before they can bill DSHS.
11	**Continuing Medication Therapy**	05/12/03	**Q.** If a Brand name medication has been started by another plan or fee-for-service, does the current plan have the obligation to continue the medication or can the current plan request the client first try a generic? **A.** The current plan must evaluate the medical necessity and continuity of care before making any change in current medication therapy.
12	**Spinal manipulations - Doctor of Osteopath (DO)**	05/12/03	**Q.** Are spinal manipulations performed by Doctor of Osteopath (DO) covered by Healthy Options? **A.** Yes - Spinal manipulations by a DO are covered when medically necessary. Spinal manipulations by Chiropractors are only covered for children when referred as part of an EPSDT exam.

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
13	**Sensory Integration Therapy**	05/23/03	**Q.** Is occupational therapy for **sensory integration therapy** for a child with autism covered when it is to help a child behave better at school? It does not seem that medical necessity applies just to make it easier to make a child behave? **A.** Autism is a medical condition. So the definition of medical necessity would apply to help alleviate a handicapping condition. **Medically Necessary Services** means services which are reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee requesting the service. For the purpose of this agreement, course of treatment may include mere observation or, where appropriate, no treatment at all. Medically necessary services shall include, but not be limited to, diagnostic, therapeutic, and preventive services that are generally and customarily provided in the service area (WAC 388-500-0005.)
14	**Continued Therapy**	5/23/03	**Q.** How long must a plan provide **continued** occupational **therapy** for sensory integration? One example is with a 4 year old who has had a total of 75 OT visits and there is a request for more, but there is no evidence that continued therapy would be of benefit. Does DSHS require periodic re-evaluations to show continued benefit? **A.** How the plan treats autism and for how long is up to the plans. The health plans cannot have a "blanket" denial policy that sensory integration is never covered. The health plans may apply their own criteria for deciding when and for how long to provide services on a case-by-case basis, using such medical indicators as progress notes, expected outcomes/prognosis, evaluation by the prescribing provider, etc.
15	**Neurodevelopment Centers**	6/11/03	**Q.** Can a plan use neurodevelopment centers as a means to provide early intervention services for Healthy Options clients? **A.** Yes - As long as medically necessary care is not interrupted.
16	**Waiting lists**	6/11/03	**Q.** What if there is an extensive waiting list for an appointment – how long is acceptable to wait? **A.** Acceptable wait times are listed in Section 4.4 Appointment Standards of the Healthy Options contract.
17	**Plateaus in care**	6/11/03	**Q.** How does a plan factor in plateaus in therapy when authorizing care? **A.** Authorizing care by the plan is done on a case by case basis with the consideration of the Medically Necessity of the treatment.

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
18	**Billing Clients**	6/11/03	**Q.** Can a hospital-based group who works in a Medicaid contracted hospital balance bill Medicaid clients? **A.** No - A hospital-based group cannot balance bill clients in Managed Care. Premiums paid by DSHS to the health plans cover all covered services provided to clients enrolled in managed care.
19	**Billing Clients for "No-Shows"**	05/26/04	**Q.** Can a provider bill a client a "no-show" fee if the provider can clearly show documented and communicated policy was shared with the client? **A.** No – Missed appointments are not distinct reimbursable services. Medicaid considers missed appointments as part of the provider's overall cost of doing business. Federal and state law prohibits Medicaid providers from billing for missed appointments as it hinders recipients' access to services.
20	**TMJ - Benefit**	11/23/04	**Q.** Is Temporomandibular Joint (TMJ) Disorder a covered benefit by the Healthy Options Plan? **A.** NO – TMJ is a dental service and is only covered for children under MAA's fee-for-service program. TMJ is not covered for adults either fee-for-service or through Healthy Options.
21	**Immunizations for International Travel**	05/28/04	**Q.** Are immunizations needed for international travel covered by Healthy Options? **A.** Healthy Options plans are not required to provide immunizations for international travel. Medical Assistance Administration will cover the immunizations Fee-for-Service, **only if** prior authorization is obtained from the Medical Management Pharmacy Prior Authorization unit.
22	**Lice combs**	05/28/04	**Q.** Is a prescription required for lice combs? **A.** Yes - To pay fee-for-service claims, MAA requires a physician's prescription according to the instructions in the Non DME Billing Instructions located at: http://fortress.wa.gov/dshs/maa/download/cpt_agreement.htm.
23	**Newborn Enrollment**	05/28/04	**Q.** Which Healthy Options plan are newborns enrolled in? **A.** MAA enrolls newborns in the same Healthy Options Plan the Mom is enrolled with at the time of delivery.
24	**Other Insurance Codes**	05/28/04	**Q.** What does the code "HM99" in the "Insurance Column" of the Medical ID Card (coupon) mean? **A.** Clients who are covered by private managed care plan (usually provided by the non-custodial parent) insurance may not be able to access the private health plan's network. If the client lives outside a 25 mile radius or 45 minute travel time from a network provider the private insurance coverage is coded with HM99. This makes the client's provider aware that they have other insurance which maybe billed for emergency services, but routine services should be billed directly to Medicaid. These clients are also eligible for enrollment in a Healthy Options plan because they cannot access services from their private managed care plan.

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
25	**Birthday Rule to Calculate Premium Rates**	05/28/04	**Q.** What date does MAA use to calculate the "age" when paying premiums to the plans? **A.** Premium payments are paid using the client's actual age on the last day of prior month for which the premium is paid. If the client's birthday occurs at any time during the month the age for premium calculation is not changed until the month after the birthday.
26	**Medicaid Program Codes**	06/02/04	**Q.** What do the "C, H, N, S, and U" codes stand for on the Monthly Managed Care Report's Summary tables? **A.** The codes are used by the state to identify various medical programs in our Medicaid Information Management System (MMIS). DSHS clients eligible for managed care programs (Healthy Options, Basic Health Plus, and SHCIP) are coded with these medical program eligibility codes in MMIS. The summary of total DSHS clients in managed care is available for all three programs Healthy Options, Basic Health Plus, and SCHIP located on the DSHS MAA Healthy Options website at: http://fortress.wa.gov/dshs/maa/HealthyOptions/index.html The medical program codes stand for: "C" = Family Medical Program under Temporary Assistance for Needy Families (TANF) "H" = Children's Medical Program "N" = State Children's Health Insurance Program (SCHIP) "S" = Pregnant Women's Program "U" = General Assistance Program eligible for Medicaid
27	**HO Contract Amendment Process**	06/24/04	**Q.** Will there be a Contract Amendment for the changes to the Risk Adjustment factors? **A.** No. The Risk Adjustment factor change is already documented within the contract. Updated Exhibit B's are sent to the plans when new Risk Adjustment Factor are implemented.
28	**Lost or Stolen Prescriptions**	09/14/04	**Q.** Are health plans responsible to replace lost or stole prescriptions for Healthy Options/SCHIP/BH+/SMED enrollees? **A.** YES - Health plans are required to replace lost, stolen or destroyed medications at no cost to the Healthy Options/SCHIP/BH+/SMED enrollees. Under DSHS Billing Instructions and Regulation, this requirement is allowed at least once in a 6 month period per medication. Health Plans are required to cover the same scope of service as Fee for Service. The references related to this subject are: 2003-2005 Healthy Options/SCHIP Contract sections 10.1., 10.13., 11.1.1., 11.1.2., MAA Billing Instructions "Prescription Drug Program" # Memo 03-55 MAA - (Revised October 2003) – Pg. C.8 - Coverage/Program Limitations and WAC 388-530-1100(5)(b)(iii).

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
29	**Supplemental Premium Billing Remittance Advice**	09/14/04	**Q.** The new HIPAA formatted electronic 820 Premium Payment Notice only gives information on "PAID" billings. The 277U, Unsolicited Claim Status Information, provides information of "SUSPENDED" billings. Since the health plans do not receive the electronic 835 Remittance Advice, how do we find out if the claims we bill MAA for (Delivery Case Rates (DCRs), Supplemental "S" women Premiums, retro newborn Premiums, etc.) are denied? Can MAA include "denied" claims status information on the 277U transaction? **A.** To determine the status of claims individually or in batch requests, the plan will need to use the 276/277 electronic Claims Status Inquiry and Response transaction. This transaction is available for all MAA providers including health plans with access to the WaMedWeb website at: https://wamedweb.acs-inc.com/wa/general/home.do
30	**Electronic Claims (837P) Claim Frequency Type Code**	09/14/04	**Q.** Please clarify how the plans should use the "Claim Frequency Type Code" when rebilling DCRs, Supplemental "S" women premium enhancements, retro newborn premiums etc.? Our assumption for the Claim Frequency Type Code in the 837P transaction is: Use "1" (original claim) if the bill is the original or when a re-bill is less than 365 days old. Use "7" (replacement) if the bill is a re-bill that is more than 365 old. When using "7" include the original ICN in the Claim Original Reference Number (Loop 2300/REF02). **A.** YES – the assumption above is correct. MAA uses the term "re-bill" to mean that an original claim was completely denied on the Remittance Advice. The Billing Guide for HO/BH+/SCHIP health plans, requires providers/billers to re-bill a claim as a brand new "original" claim UNLESS the date of service is more than 365 days old. MAA will deny all original claims that are more than 365 days old for "untimely" filing.
31	Negative Payment Amounts in the 820 Premium Payment Notice	09/14/04	**Q.** The 820 Companion Guide from MAA (dated March 24) states that adjustments to previous payments will come in a Loop 2320B in an ADX segment. There are lots of negatives in the file, but no ADX segments. Has MAA decided not to send adjustments in the 2320B loop? **A.** The negative amounts reported in the 820 transaction are not the "adjustments" described in the ADX segment of Loop 2300B. Since MAA pays premiums prospectively, the negative amounts actually represent a recoupment because a client's eligibility or enrollment changed after premiums were paid in the previous month. A plan would receive a term notice in the 834 eligibility file for the client when the 820 has a negative premium payment amount.
32	**Retro Newborn Premium Payment**	09/14/04	**Q.** When a Mom is admitted to the hospital under Fee-For-Service (FFS) in one month, delivers the baby the following month and is assigned to a managed care plan in following same month, is the plan entitled to the retro newborn premium payment for the baby's month of birth? Scenario: Mom admitted to hospital 02/28/04. Mom assigned to health plan effective 03/01/04. Baby born on 03/02/04. **A.** YES – The health plan is entitled to the retro newborn premium for March. However, the plan is **not** entitled to claim a Delivery Case Rate for the Mom because DSHS paid for the Mom's hospital inpatient stay.

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
33	**Client Information – SSN Update**	9/14/04	**Q.** When the health plan receives information about a newborn's SSN, what is the proper procedure to follow so that MMIS is also updated with the SSN? **A.** The primary information on client eligibility and demographics is maintained and updated in the DSHS Automated Client Eligibility System (ACES). The client, in this case the Mom, must notify the local Community Service Office (CSO) when the baby receives the SSN so that the information can be updated in ACES and through a nightly interface it will update MMIS. All demographic information must be updated in ACES in order for MMIS to provide corrected information to the health plans during the monthly enrollment process. **NOTE:** The CSO does not need, nor can they require the family to apply for or provide the SSN information on a newborn. About 6 weeks before the child turns one year old the family is sent a review form asking for the child's SSN. If the SSN is not returned, the CSO will then look at terminating assistance for the child. **NOTE:** When the CSO worker enters a SSN into ACES, it interfaces with the Social Security Administration (SSA) and verifies that the number provided is a federally verified number. This match with SSA is based on the SSN in ACES not on the person's name and birth. Until a SSN is input there is nothing to match between ACES and SSA.
34	**Oral Pathology Services**	4/29/05	**Q.** For managed care clients, who (DSHS or the Health Plan) is responsible to pay claims for oral pathology services? **A.** The Healthy Options/SCHIP contract with the health plans excludes dental program services and related ancillary services. Payment for oral pathology services is based on whether the service was dental related or medical in nature. The health plan is responsible for payment of all medically necessary services that are not related to excluded dental services.
35	**Genetic Counseling**	5/12/05	**Q.** How does DSHS cover genetic counseling for clients enrolled in Healthy Options? **A.** In general, DSHS covers Prenatal Diagnosis Genetic Counseling on a fee-for-services basis and this benefit is excluded from the services covered by the HO/SCHIP Contract. The HO/QCHIP contract states "Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. Genetic services for pregnant women beyond Prenatal Diagnosis Genetic Counseling are covered as maternity care when medically necessary, see Section 11.1.8.3." This means that the provider should bill MAA for Prenatal Diagnosis Genetic Counseling services and bill the Healthy Options plan for genetic services for pregnant women beyond the Prenatal Diagnosis Genetic Counseling as part of the covered maternity services when medically necessary.

Frequently Asked Questions
Managed Care Plan Issues
06/27/2005

#	SUBJECT	DATE POSTED	QUESTION (Q.)/ANSWER (A.)
36	**Definition of "Admit" to Inpatient Facility**	6/09/05	**Q.** Please clarify the DSHS Definition of **admission to inpatient facility.** Per the Billing Guidelines page H2, Admission hour is "The hour the patient was admitted for inpatient care." If the patient is admitted through the Emergency Department, (ER) is the time of admission the person is admitted to the ER or the time the patient is moved to a ward? **A.** The "admission hour" is the time the patient actually arrives to a ward/floor for inpatient services. The time spent in the ER is included in the ER revenue and ER procedure codes. Per WA 388-550-6000 (4) DSHS does not for cast room, emergency room, observation room, treatment room and other room charges in combination when billing periods for these charges overlap.
37	**Dual Coverage in Healthy Options**	6/8/05	**Q.** Can a client who becomes eligible for Healthy Options/SCHIP program enroll in the same managed care health plan where the client has commercial or Basic Health benefits? **A.** Clients with insurance coverage comparable to Healthy Option/SCHIP are either not enrolled in HO/SCHIP or are disenrolled when DSHS confirms the comparable coverage. A client may not have coverage by the same plan for HO/SCHIP and commercial/Basic Health. If such coverage is discovered the client is disenrolled retroactively from HO/SCHIP.